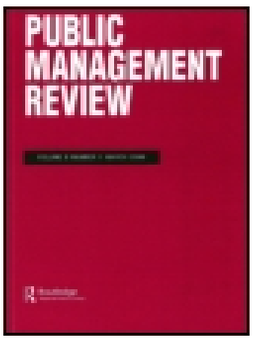

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Experts' contribution to strategy when strategy is absent. A case study of quality experts in hospitals

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ABSTRACT

This study investigates how new categories of experts can contribute to strategy development in public organizations. Interplay between managers and experts was analysed using principal-agent theory, stewardship theory, and partnership theory, each assigning the experts different kinds of strategic contribution. Results show that experts may contribute to an iterative and emergent strategy process as stewards through a consultative process method that lets the means guide the goals. Experts' knowledge of what other actors in the organization perceive as important guides the experts' application of the technical methods and processing.

KEYWORDS Agent; competing logics; experts; managers; partner; steward

Introduction

Relationships between experts and managers have become an increasingly pertinent area of study in public management research as new public management (NPM) has become institutionalized in public organizations. NPM is supposed to increase the strategic space for public organizations and public managers (Ferlie and Ongaro 2015). Therefore, strategic management is argued to be vital for shaping the performance of public organizations (Andrews et al. 2009; Rosenberg Hansen and Ferlie 2016). However, another consequence of NPM is the expansion of support functions held by different kinds of experts (Ackroyd, Kirkpatrick, and Walker 2007), such as controllers, HR experts, and quality experts (QEs). While these new categories of experts aim to contribute to the strategy development of their organizations (Cohen 2001), the interaction between experts and managers appears problematic in many studies (McGuire, Stoner, and Mylona 2008; Mintzberg 2017). Experts are knowledge workers who are trained to provide the latest know-how regarding certain principles and practices in a specific area (Styhre et al. 2010). The experts' main difficulty in the interaction seems to be an inability to affect the line managers' operational and strategic decision-making, whereas the managers lacked control over or collaboration with the experts. It can be assumed that this interaction is especially problematic in healthcare organizations because of their highly institutionalized competing logics

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(Reay et al. 2017). In healthcare, experts must relate not only to the managerial logic, but also to professional logics.

One explanation for these interaction problems concerns the high degree of centralization, where experts are organized in remote departments and isolated from the operational managers' decision-making (Cacciatori and Jacobides 2005). Another explanation is that experts' unclear roles make it difficult for them to gain attention and recognition. Some studies have argued that experts' roles cannot be determined solely by the expert function itself and must be defined in interaction with such groups as middle managers (e.g. Procter and Currie 1999). For experts to become strategic partners, rather than just a force for superficial change, they would need to understand how other actors perceive them and also other actors' interpretations of events that occur in the change process. Caldwell (2003) concluded that the strategic partner role for experts appears to be more about aligning expert strategy and the strategy of the organization. Truss (2009) found that the role of experts is shaped by the setting in a co-evolutionary process, together with individuals and groups beyond the expert function and in their own informal and emergent practices. Thus, the outcome of an expert functions' role positioning is unpredictable. It is possible, but rare, for its members to achieve strategic positions.

A public sector organization, with its goal conflicts, is different and more complex than a private company, which is the template by which the NPM reforms are guided (Mills, Bradley, and Keast 2019). In the public organization context, one cannot assume that managers at different levels and experts share common goals, which may make it difficult for the experts to implement changes that are consistent with both top managers' managerial viewpoints and middle managers' professional ambitions. Probably, the extended knowledge the experts bring to the organization will not be as useful as was expected when they were hired. Therefore, despite high hopes, their contribution to the organization may be marginalized. Accordingly, the experts are embedded in a context that may preclude rational solutions from speaking for themselves. The recently engaged experts must develop pragmatic solutions in conjunction with the powerful professional actors already established in the organization, to introduce system logical aspects into an individual logic context (Eriksson et al. 2019). It appears to be especially difficult for experts to exert influence on the core operations within the public organization context.

However, the extant research provides limited information about strategy development as an emergent process through several different organizational actors' interplay, such as the extent to which line managers can control other internal actors' strategies (Bryson, Berry, and Yang 2010). Literature on public strategic management, where 'strategy is about purpose, direction and goals' (Johanson 2009, 873) usually focuses on plan formulation, content or implementation, and describes the strategic process in discrete steps. However, the strategy process is usually described in discrete steps but ignores iterative processes that could offer insights into how strategy develops (Poister, Pasha, and Edwards 2013). The iterative processes are especially relevant in public organizations, where a plurality of persons interacting in manifold ways will usually dynamically form a collective strategy (Ferlie and Ongaro 2015). Yet, the centrality of NPM in current public sector organizations tend to place managers in the centre of this interactive process.

The aim here is to explain experts' function in the iterative and emergent strategy process involving different actors, with particular focus on experts' contribution to

strategic management in the interplay with line managers. Accordingly, we intend to help explain whether experts have the potential to exert a strategic function outlined by the theories upon which NPM rests.

We studied the work of QEs and their interplay with the line managers, including top managers and operational managers, at a mid-sized Swedish hospital. QEs have found their basis in what has been called improvement science, informed by the quality science field translated to the healthcare sector. We used three theoretical perspectives – principal-agent theory, stewardship theory and partnership theory – each assigning the QEs different functions in strategic contribution, to analyse the interplay between managers and QEs. The three perspectives explain how experts can have varying functions in the organization's strategic development.

Experts' contribution to strategy

The literature provides several concepts regarding how experts within organizations act to make a strategic contribution (see Peterson 2008). There are at least three main reasons why public management research is not well developed concerning experts in staff functions and their influence on strategy. First, strategic management has only recently received attention in the public management literature (Rosenberg Hansen and Ferlie 2016). Second, having strong staff functions with experts is a relatively new phenomenon in public organizations, often related to NPM and increased accountability pressures (Andersson and Liff 2012).

Traditionally, public organizations have mainly been professional bureaucracies with small support functions that have no expectations of contributing to strategy processes (Currie and Procter 2005). Third, while strategic management tends to be strongly related to managers, the situation within professional bureaucracies as healthcare organizations is more complex (Ferlie and Ongaro 2015). The presence of powerful professional groups limits the potential for managers to have an autonomous strategic role (Currie and Procter 2005) and makes the strategy process multifaceted and multilevel (Powell et al. 2019).

Concerning the public sector especially, studies on the personnel/HR function offer insights into how experts should act in order to become strategic, as well as the difficulties in achieving this status (Dutton et al. 2001; Procter and Currie 1999; Ackroyd, Kirkpatrick, and Walker 2007). Dutton et al. (2001) demonstrated the process whereby experts within different areas of expertise become influential regarding top management's strategic agenda by drawing on relational, normative and strategic contextual knowledge. Experts use this knowledge to achieve issue-selling objectives (Dutton et al. 2001), including packaging, involvement and timing. Packaging involves aligning the message to the organization's strategic direction and presenting facts in the right order and form; involvement requires co-ordination of similar targets of interest to the right people; and timing means waiting for the right moment to raise an agenda issue. Dutton et al. (2001) argued that success requires the involvement of a wide range of colleagues early on in the process, particularly people at or above their own level. Considering the complexity of public healthcare organizations, it is not only about involving managerial levels, since the strategy process is not solely related to managers (Ferlie and Ongaro 2015). Experts keep influential people informed and persist in their selling efforts, while taking advantage of timing to help them decide when to 'sell' the issue and when to hold back.

Research on experts in the private sector, such as risk managers, are also relevant for understanding what it takes for an expert to influence strategy. One challenge concerns structural traits. In an organization with large centralized staff, experts may become isolated from the line managers' decision-making processes (Wahlström 2009), which makes it difficult for experts to integrate their knowledge in the management control system and thereby in the organization's strategy. Another problem concerns managers' difficulties relating to information, based on methods that are difficult to understand (Hall, Mikes, and Millo 2015). Arena, Arnaboldi, and Azzone (2010) found that social interaction between experts and managers is necessary to make managers aware of the meaning of experts' central concepts. If managers understand the underlying assumptions of these concepts, their methods become less of a black box and experts' recommendations become easier to evaluate. Hall, Mikes, and Millo (2015) even suggested that the experts should use their analytical tools as communicative support. Furthermore, ideas should be bundled with other strategic matters and linked to the strategic decision-making process (Meidell and Kaarbø 2017). These results from the private sector have generic value and are also important in public organizations, since they basically relate to isolation of different functions and difficulties to relate to each other's knowledge bases, which can be assumed to be even more evident in public healthcare organizations regarding its segmented character (Glouberman and Mintzberg 2001).

Studies in the public and private sectors regarding experts' contribution to strategy have generally understood that the contribution is conditioned by the extent to which experts' approaches and actions are aligned with the organizational mission and goals, and the extent to which experts' knowledge is used in forming strategy (Pritchard 2010; Peterson 2008). To achieve successful cooperation between managers and experts, previous studies have pinpointed the importance of both uniqueness and differences in the experts' competence (Carlile 2004; Dutton et al. 2001; Hall, Mikes, and Millo 2015), as well as connectedness or similarities to managers' organizational knowledge (Freidson 1970/2007; Truss 2009; Arena, Arnaboldi, and Azzone 2010). The literature explains experts' difficulties in achieving influence on strategy as either related to the difficulties in achieving enough similarities or differences in relation to managers.

Studies have indicated that the degree of similarity between experts' knowledge and the information managers need is too low to see experts as strategic partners, and that there is a need for better integration of the experts' knowledge in the decision-making process (Meidell and Kaarbø 2017; Hall, Mikes, and Millo 2015). In the literature, the dominant explanation for experts' difficulties in becoming strategic is a combination of too little similarity and too much difference.

The functions of the experts in the interplay with managers

We analyse the interplay between QEs and managers based on experts having one of three ideal typical functions: as agents (according to principal-agency theory), stewards (according to stewardship theory), or partners (according to partnership theory). The different theories mean different forms of strategy processes, and thereby different possible functions for the experts in these processes.

The control function – the principal-agent theory

The principal-agent theory describes the relationship between two parties, where work is delegated from the principal (here, the manager) to an agent (the QE). According to this theory, the role of a principal is to exercise control over the agents' decisions and secure the experts' alignment with the principal's interests (Eisenhardt 1989). However, this is problematic since the agent is assumed to be driven by opportunistic self-interested behaviour (Davis, Schoorman, and Donaldson 1997), which implies that there is goal incongruence between self-interested agents and the principal (Van Slyke 2007). Thus, principals need to monitor the QEs decision-making process and ratify it, evaluate the performance of the experts, and recruit and replace them if necessary. The strategic function of the interplay is reactive and requires a retrospective analysis of the experts' behaviour.

To identify a relationship as an expression of the expert as an *agent*, the expert is supposed to:

(a) Initiate investigations following the manager's approval, complete the investigation and let the manager evaluate/draw conclusions from the results of the investigation.
(b) Accept ideas to be questioned by the manager and have suggestions rejected by the manager.
(c) Accept that the manager decides regarding the salary and the expert's promotion.

The support function – the stewardship theory

According to the stewardship theory, the relationship between management and experts is based on trust and common interest in the organization's success (Davis, Schoorman, and Donaldson 1997). The difference between the principal-agency theory and the stewardship theory is the underpinning assumptions about what motivates and drives actors to do their best. In stewardship theory, actors are seen as altruistic and work in the common best interests of the organization (Dicke and Ott 2002). The experts consult with management and offer advice regarding what they feel are the best ways to achieve the organization's goals, which means striving for goal alignment between experts and managers (Van Slyke 2007). Thus, experts take a proactive role in strategic issues (Huse 2007). According to stewardship theory, management should take a proactive role in its control function, including evaluating the results of strategic policies and actions.

To identify a relationship as an expression of the expert as a *steward*, the expert is supposed to:

(a) Request autonomy when acting from a staff position to initiate investigations, according to their professional opinions and norms.
(b) Act as a team player, if necessary based on a sense of duty, to achieve organizational goals.
(c) Request recognition of own professional performance.

The partner function – the partnership theory

According to partnership theory, management and experts are strategic partners and both parties should be involved in all strategic stages and decisions (Teisman and Klijn 2002; Thomson, Perry, and Miller 2009). The strategic function is characterized by an interest in both short- and long-term goals on an organizational level and measurements, including resource allocation to achieve these (Edwards and Cornforth 2003). These goals and measurements may concern what the organization should produce, to whom and how. In this case, the QEs mainly address how a system perspective rather than just an individual perspective on patient treatment should guide resource allocation and how the critical processes should be re-engineered to increase the resource efficiency.

To identify a relationship as an expression of the expert as a *partner*, the expert is supposed to:

(a) Initiate and participate in discussions with the managers concerning the vision, mission and goals on their organizational level.
(b) Initiate and participate in discussions with the managers concerning activities that are necessary to achieve the goals on their organizational level.
(c) Initiate and participate in discussions with the managers concerning resource allocation to make it possible to achieve the goals on their organizational level.

By analysing the empirical material based on one theoretical perspective at a time, and then comparing these different analyses, the different theories become perspectives/lenses that we alter to enable a deeper understanding of experts' function in strategy processes.

The context and case setting

Policy context

Public healthcare in Sweden is characterized by an institutionalization of NPM similar to other countries in western and northern Europe (Pollitt and Bouckaert 2004). NPM has made managers accountable for resources and has placed resource restrictions on the professionals' ambitions to develop healthcare based on medical needs and medical development (see Simonet 2013). While the NPM era may appear outdated because of all reported dysfunctions succeeded by other reforms, NPM logic has proven resilient and remains embedded in public organizations (Caffrey, Ferlie, and McKevitt 2019).

However, NPM has not exchanged existing governing regimes based on professional logics; rather, it has increased the complexity in public healthcare, since it persists over time alongside contradictory logics (Andersson and Liff 2018). Glouberman and Mintzberg (2001) explained this institutional complexity by describing healthcare as consisting of different worlds with different values and priorities. Community logic is represented by politicians versus control logic represented by managers, and different professional logics are represented by healthcare professionals, leading to tensions among politicians, managers and healthcare professionals. NPM has strengthened control logic, enabling it to challenge the previously dominant professional logics in the studied Swedish healthcare system.

Case setting

The study was conducted at a sub-regional emergency hospital in Sweden that provides basic and specialized care in medical, surgical and psychiatric specializations. The hospital is mid-sized, by Swedish standards, with approximately 4000 employees, and is governed by politicians in a hospital board that define objectives and instructions. The hospital is organized in a line-staff organization with a top management team consisting of a chief executive officer with two vice executive officers, five managers of chief executive's staff, chief physician and chief nurse, and 12 department managers organized in the line based on different care specializations. The QEs constitute one of the five staff categories, directly linked to the chief executive officer of the hospital. The QEs' position is that of a staff member and therefore cannot formally exert power over the line mangers' decision-making or actions. Accordingly, the QEs have no staff liabilities and are not financially accountable. This position is in accordance with the traditional staff position of, for example, HR experts in healthcare and other staff positions in other organizations (Crozier and Friedberg 1980). Even though QE is a staff category, subordinated under the head of QE, all QEs spend approximately half of their time in connection with one of the department managers. This is an attempt to combine a centralized solution (QEs working together as staff) and a decentralized solution (QEs are connected to one department that they learn about).

Initially, QEs were mainly recruited among registered nurses working at the hospital, with ambitions to develop the wards' care processes. Obtaining a position as a QE was regarded as a promotion to this category of staff members. During the first few years, the head of the QEs organization was a physician with special interest in quality improvement work in healthcare. Gradually, young university graduates have been recruited, with specialized skills to map and analyse work processes.

At the time of this study, 20 people (including the manager) were engaged as QEs. Approximately half the staff had a background as nurses and the other half were well-educated specialists in quality work, but did not have experience in healthcare organizations.

In the first few years, the declared assignment was stated as: the staff should support the department managers and the unit managers in improvement work, where the staff members' technical skills and care-giving experiences were considered necessary to develop care and work processes and patient flow across healthcare specialities. Subsequently, this idea of the assignment was changed slightly to include members of the staff who did not have care-giving experience. The staff also have assignments from the upper management, such as incident analysis and risk analysis, which take approximately half of their capacity.

Thus, assignments come in both from top management and from the decentralized management levels, which means that the QEs have to handle central and local governance simultaneously. Internally, the incoming requests for assistance in improvement work and investigations of different kinds are allocated by the head of the staff, usually to a single staff member. The progress in ongoing works and internal matters is discussed at weekly staff meetings, in which all members of the staff participate.

The studied setting is a hospital, which is similar to the archetypical acute care institution described by Glouberman and Mintzberg (2001), in that situations in which outputs and work cannot be standardized require coordination between managers and

experts based on mutual judgement. This is particularly the case when experts, such as QEs, are positioned in a support function outside the operations at the unit and have the function of supporting the managers inside the line organization in solving complex issues at the unit.

Method

Participants and data collection

We chose case study as our research method (Czarniawska 2014; Silverman 2013) in order to study QEs' and managers' interactions in ongoing daily activities. The studied case allowed us to study multifaceted phenomena in a context-sensitive way in order to better understand the ongoing processes (Flyvbjerg 2006; Eisenhardt and Graebner 2007). The case selection is done through theoretical (instead of representative) sampling in order to identify an analytically typical case, which allows for generalization (Flyvbjerg 2001).

We initially used internal documents, which have a general character, to give us a contextual understanding to guide the interviews and interpret the interview answers. The first head of the staff was interviewed to obtain a perspective of the staff´s development during the first few years. In a first interview round, 18 QEs and their manager were interviewed. In a second round, four department managers were interviewed to get their experiences of the cooperation with the QEs. All interviews were semi-structured and allowed for follow-up questions (Kvale 1996; Silverman 2013). Since the validity of the data depends on its authenticity, openness was encouraged. The interviews were held using a conversational tone, asking respondents about real events they had experienced to help them to recollect lived experiences (Van Manen 1997) and avoid answers that reflect social imprints (Alvesson 2003). The interviews, which lasted 50–60 minutes each, were audio-taped. The study spanned 18 months. Reliability in the analysis of the data was ensured by transcribing the taped interviews verbatim.

Data analysis

The analysis was a gradual, iterative process of interpretation and sense-making in five steps. The *first* step began immediately after the interview, by discussing and reflecting upon notes about interesting answers. In the *second* step, after the transcription of each interview, the most significant viewpoints and ideas were again noted and reflected upon and guided forthcoming interviews, where new questions were asked. In the *third* step, after all the interviews had been transcribed, we read and re-read the transcriptions and our position as two researchers engaged in the encoding helped us systematically structure the material in a search for themes that were sorted according to their descriptive content (Kvale 1996; Corbin and Strauss 2008).

The empirical data influenced the choice of a theoretical framework. We noticed a wide range of intentions and experiences of the functions of the QEs from the empirical data, which indicated the need to use several different theoretical perspectives. Thus, we chose the three mentioned ideal typical functions, which in the *fourth* step guided the categorization of second-order theoretical categories that were used to analyse the first-order categories. Three questions guided the first-order categories: Do

QEs have a function as agents? Do QEs have a function as stewards? Do QEs have a function as partners? The analytical characteristics in these three functions were used as precepts. The analysis section is structured according to responses to these questions. Finally, in the *fifth* step, an iterative analysis of the coded data was performed in order to obtain examples and illustrative quotations of each of the categories (Charmaz 2006; Denzin and Lincoln 2011). The quotations presented in the results section were chosen because they were typical and able to provide qualitative evidence of what is stated.

Results

Present state, reflections and consequences

Quality and processes

Process/flow orientation is a central philosophy in quality work. This means that care paths are viewed as processes that can be mapped and improved based on linking mapped activities effectively.

> Although I don't have a background in healthcare, I can understand a process flow. I can map the processes and see the connections that must be more effective between different activities. (QE19)

Improving the processes indirectly contributes to the economic efficiency of the operations, but the interviewees never use economic arguments for their improvement proposals.

> We don't talk about finances. We think that if we have order in our processes and if we do the right things from the beginning, then it will have a positive effect on the economy. And talking about economics is no fun. People in healthcare don't like it at all. (Head of QE)

Quality and processes are the most important identity words associated with the quality expert function.

QEs also perform incident analyses, which are regulated by law in the event of incidents and medical injuries. This involves mapping what has actually happened in order to be able to deduce whether it is based on system problems that can be improved. The incident analysis work is extensive.

> Last year, we had over 60 incident analyses, which is quite a large task, including interviews with relatives, patients, all staff and so on. And then it should be compiled according to a certain method. (Head of QE)

The QEs perceive that these incident analyses, as they are performed afterwards, need to lead to tangible changes for future processes, but that seldom happens.

> Sometimes, we do an incident analysis and realize that 'We have done an incident analysis on this before'; it has happened before. Then, it feels pretty pointless, what we do. (QE10)

The QEs' sole responsibility is to carry out the actual incident analysis, whereas department managers have the overall responsibility, and therefore also decide whether anything should change based on the results of the incident analysis.

Method support

QEs often describe their function as 'method support', but it is not self-evident what that means.

> What is a quality expert? Is it just a method support, or can you be involved and drive something? Those who come externally may think more about being a method support, but those who come from within, they see that changes need to be made and want to be involved in driving change … and may not see the method as the most important. (Head of QE)

The discussion about the meaning of method support is linked to whether it is important for QEs to have a background as a nurse. The externally recruited QEs have a tendency to emphasize the context-independent nature methods, whereas the internally recruited nurses emphasize the importance of understanding the healthcare context.

> Our methods in themselves can be seen as context-independent, but experience from healthcare can mean better precision when using them. (QE6)

Criticism was also levelled towards the label method support among QEs, as some feel it does not correspond to the work they do:

> *I don't use the term 'method support'. Of course we use methods, but there is no passive delivery of methods. We have to be group leaders, project leaders, conflict solvers and so much more*. (QE 12)

Regardless of the attitude towards method support, the work is driven by process development and incident analysis from a patient perspective.

The label method support has implications for the perceived agency of QEs:

> Sometimes I feel that the method becomes more important than the result, because you have no responsibility for the result. 'Yes, but you still have the responsibility to provide and use a method that produces the results the customer wants'. 'No, it is not my responsibility,' it is said then, 'but the managers can take responsibility'. (Former head of QE)

One interpretation of method support is that it is not merely a generic ability. Process mapping requires that the method be translated into the context, and method support also contains thoughts about realistic solutions.

The QEs strongly emphasize that the know-how of a process is closely linked to method knowledge. Use of the method needs to be motivated and the QEs need to acknowledge participating healthcare professionals' commitment, time, abilities, etc. By making the method relevant for problem solving, it becomes relevant for the problems experienced by the operations. It seems particularly important to get the management involved in allocating resources for process development and to persuade management to be persistent in supporting changes. Process knowledge means that the meaning of being a method support does not become a demarcation away from the result being achieved. However, a central element of the QE view is that QEs should have a consultative approach and not try to enforce a solution proposal.

Ways to get assignments

Assignments from department managers are often generically written documents. Together with QEs' beliefs that department managers should not direct their work, QEs manage their assignments relatively independently. Proposals for the assignments come from QEs' contacts with employees within the operations, or from views that emerge about an activity when it is discussed at meetings with representatives of the operations. The assignment documents are given to acknowledge that the manager supports the initiative and legitimizes it in the information about the initiative within the operations concerned.

An assignment document can also specify who should take responsibility for implementing the decided measures and how its effects shall be followed up on. However, since quantitative goals are usually lacking, it can be difficult to determine what has been achieved and the effects can be perceived as diffuse.

Given the formalized way that the department managers control the assignments and the lack of operationalized goals with the assignments, the QEs' process orientation can enable them to create goals by the means provided. The QEs can contribute to overall goals implicitly through their methods. The term 'method support' can indicate that QEs do not have a goal concerning process development. However, based on experience from healthcare, the means can shape the goal, rather than vice versa. Thus, the QEs can help operationalize the goals of operations. The questions are how consciously this happens, how desirable it is, and how clear it can be when discussing within a project where the quality experts are involved.

The QEs' strategies for development of operations with local connection

How QEs contribute to the development of operations is influenced by many factors. These include the QEs' own perceptions of the function (centrally located as a staff department but working consultatively locally), their methodological knowledge, the department and unit managers' involvement in improvement work, and a range of contextual conditions in the various activities relating to staffing and type of care processes (psychiatry or orthopaedics). The QEs' professional background also mattered. In several of the interviews, the internally recruited QEs declared that their background as nurses gave them legitimacy to ask challenging questions and better access to line managers, whereas the externally recruited QEs described situations where they had to prove the relevancy of their knowledge. These impressions shared by the QEs were also confirmed by the managers. All of the QEs perceived their function as complex:

> To work in a consultative way, being centrally located and then you go out and work. The department manager should be satisfied, but still you should be able to say that this is not the right thing to do; you need to do this instead! Yet, it is you as the manager who decides. (Head of QE)

Similarly, department managers perceive QEs' function as unclear.

> The role of the QE today is damn difficult. We try to use our QE resources for slightly different things; for what depends a lot on the match with the department manager. This leads to increased ambiguity in the role. They are always somewhat questioned. (Department Manager A)

The department managers' overstretched work situation limits their opportunities to prioritize process development. It is difficult for department managers to identify the largest flows that need to be analysed and which are the most important types of problems to be addressed. Similarly, it can be difficult to get the department manager to reflect on the results of the mapping.

> It may seem that the department managers have low priority to take advantage of the results of the incident analyses. The department managers become the tight sector all the time, because they can't be involved in all issues. (Former head of QE)

Although QEs have ambitions to improve healthcare, department managers cannot always act on their ambitions because of competing concerns.

> They want us to do good things. They may not be driven by financial incentives at all. But they may have some kind of inherent ambition – that what makes them feel good is that they feel they have contributed so that something gets better. (Department Manager A)

The QEs are loosely controlled by the department managers and can exert influence over the action plans by operationalizing their objectives.

The QEs' strategies for development with a central connection

Hospital directors occasionally issue QEs with assignments that have a background in a regional or national initiative. An example is a decision by the regional administration to introduce what are known as multidisciplinary teams for older people with mental illness. This type of assignment can place the QEs in a force-field between politicians, who are represented by the hospital director, and the medical profession.

> There are assignments that can be perceived to come from the top like this, with production and capacity planning that can be perceived as threatening to the doctors and their self-determination, such as introducing a new scheduling tool. (QE6)

If the assignments are formulated in concrete terms, they may conflict with physicians' priorities. The traditionally vague assignments that the QEs are given reduce this risk of being politicized in the eyes of the strong professions.

> If my assignment became more specific, it would be more clearly linked to one of the sides here. The fact that it is not so specific creates an opportunity for me to balance between these two worlds. (QE1)

The ability to conduct development work in an environment with strong, sometimes contradictory forces may be achieved by doing what the QEs does, which is working according to vaguely worded assignments in line with the professional interests.

Intentions

Towards a strategic function

Department managers are controlled mainly by finances and accessibility and wish they could direct the QEs to use their expertise to analyse these issues. For example, QEs could use their expertise to contribute to the efficiency work by analysing factors that affect production and capacity and analysing queuing times and processing times. The QEs are also expected to be able to develop systems for production and capacity planning, as well as to formulate coherent strategies in this area.

> We could have a discussion about why we don't reach accessibility. We have more people than ever – now we are 30 doctors instead of 20, we are 10 nurses instead of five – but we still can't give our patients time. And then they can start figuring out that, 'Well, why could this be? What are the other parts here than staff? What is the staff doing? Where do we have our bottlenecks?' (Department Manager B)

Department managers want QEs to be placed locally, directly subordinate to them. However, the QEs want to be involved in hospital-wide strategy issues and see themselves as part of a central development.

Analysis

In the analysis section, we use the three theoretical lenses – principal-agent theory (Eisenhardt 1989), stewardship theory (Davis, Schoorman, and Donaldson 1997), and partnership theory (Teisman and Klijn 2002) – to understand the function of the experts in the strategy process. Depending on whether they have functions as agents, stewards or partners, they will contribute to the strategy process in different ways.

Experts as agents

The experts have two principals (cf. Eisenhardt 1989): the chief executive officer via the head of the experts' staff, and the department managers. In relation to the executive managers of the hospital, the experts fulfil all the criteria of being agents: (a) the managers initiate or approve suggestions of investigations, the experts complete the investigation, and allow the managers to evaluate and draw conclusions from the results of the investigation; (b) the experts accept ideas to be questioned by the manager and have suggestions rejected by the managers; and (c) the experts accept that the manager decides regarding the salary and the expert's promotion.

When the experts are fulfiling controller tasks of an administrative character, they have an unproblematic function as agents to the executive managers (see Eisenhardt 1989). However, there may be issues when conducting centrally initiated investigations or trying to implement policies decided by the hospital director or regional decisions conveyed by the hospital director. Specifically, they may interfere with the professionals' interests when positioning the physicians and the nurses in an agent relation to the experts as stand-in principals for the chief executive officer. The QEs see this function as one of being a producer of decision basis for the executive managers of the hospital and as a tool for implementing policy decisions as the main route to becoming more influential; that is, to become strategic. This route has not proven possible so far, and there seems to be at least two main explanations for this. One is that the QEs must perform a difficult and delicate balancing act between the political and managerial demands, on one hand, and the medical professionals, on the other. In this sense, it is not a clear principal-agent relationship (Eisenhardt 1989). Moreover, the question of goal incongruence is much more complex than that stated in principal-agent theory (Van Slyke 2007), since there may be goal incongruence even between different principals. If QEs are viewed as controversial in the medical professionals' eyes, it might be difficult for them to continue to work with their tasks when requested by the department managers. To avoid conflict, they need to avoid concrete change missions initiated from the top of the organization. The other explanation is that many of the QEs have a background as healthcare professionals and are driven by their desire to make improvements for the benefit of patients. They are not associated with the primary interests of the executive managers, and are therefore not regarded by them as their agents; for example, in making cutbacks in the operations. A further problem is that the executive managers lack strategic ideas of their own to develop the hospital and are therefore weak as principals, which means poor conditions for a well-functioning principal-agent relationship (Eisenhardt 1989).

In relation to department managers, QEs fulfil the first two criteria of being agents in the theoretical framework, but not the last criterion. In that respect, they have a different position than all other employees working within the departments. Therefore, the department managers are not interested in what QEs do in detail and

do not make any efforts to control them (cf. Eisenhardt 1989). Department managers accept the presence of QEs in their department's operations and find it helpful to receive the support the QEs offer. The department managers wish they could establish a principal-agent relationship with the QEs, but this route of development is blocked by the CEO's decision to keep the organizational solution, as it is symmetrical to all other staff. The visions expressed by the QEs of becoming strategists in relation to a central development strategy also contradict the idea that the experts would support the solution advocated by the department managers.

The overall impression is that QEs have the potential to act as agents in two kinds of relations; however, they are only doing so to a minor extent in both, and it seems difficult to see that a change is about to come.

Experts as stewards

The QEs largely fulfil the criteria of being stewards (Davis, Schoorman, and Donaldson 1997): (a) they initiate investigations in accordance with their professional opinions and norms; (b) they act as team players and invoke the argument about the patient's well-being and what their duty is to achieve the organizational goals; and (c) they ask for recognition of their professional performance.

With the experts being strongly identified with quality and process development, department managers know what kind of assignments the experts will propose and undertake and can trust that they are seeking goal alignment (cf. Van Slyke 2007). This means that department managers are ready to listen to the experts' proposals of descriptions and analyses. Department managers do not need to take the initiative to have the experts involved in different studies within their scope of competence. Therefore, it is relatively easy for QEs to receive formal acceptance to start a study, but more difficult to get the necessary personnel resources on a long-term basis, and even more difficult to have the department manager's attention along the process. This also explains why the routines are not necessarily changed after completed incident analyses. These analyses are mandatory, and the resources to conduct these are available without any regarded losses of the experts' capacity in any other assignments. The experts are duty-bound to fulfil these assignments even if they perceive that their effects on the routines and the operations are meagre.

Obviously, the QEs act as team players. Their process of supporting the in-process development in a consultative manner is found in the experts' understanding of their function. The experts are familiar with the members in the process development teams and welcome the opportunity to interact with the nurses involved in the teams. The experts are regarded as helpful, with good intentions, as would be expected of a steward in a common-sense meaning (Davis, Schoorman, and Donaldson 1997).

Furthermore, the experts focus on delivering excellent mapping of a process, regardless of what the outcome will be in the operations. This can be seen as an expression of upholding a professional boundary to the responsible executive managers. It may not be disappointing or demotivating from a professional point of view if the patient incident studies or the process studies do not render any consequences in the operations, as long as the studies are well performed and recognized as such among colleagues. The frequent and often long internal meetings, where the QEs present to each other what they do and have delivered, may serve the purpose of recognizing each other's professional performance.

The function as stewards enables the experts to fully exercise their competence in accordance with their values of what is important (cf. Davis, Schoorman, and Donaldson 1997). However, they risk being marginalized as partners to the managers and they have a limited strategic function because of low relevance in relation to the managers' perceived main tasks. However, the function as steward seems to offer possibilities to develop a strategic role. QEs' consultative interplay can gradually generate a more influential role regarding strategic decision-making. It is a matter of linking to perceived problems at the beginning of the process, informing department managers during the process, ensuring the department managers will be involved in the decision process and ask for follow-up results, etc. Even if the function as steward risks marginalizing the experts, it also introduces them in contexts and connections where the strategic functions are exercised.

Experts as partners

The experts rarely initiate and participate in discussions with the managers concerning (a) the vision, mission and goals on their organizational level; (b) activities that are necessary to achieve the goals on their organizational level; or (c) resource allocation to make it possible to achieve the goals on their organizational level. Judged by partnership theory (Edwards and Cornforth 2003), managers and QEs do not have such an integrated relationship and joint interest in short- and long-term goals that they make decisions together. Decision-making and policy-making takes place separately, and their strategic partnership is thereby limited (Teisman and Klijn 2002).

Integrated analysis of QEs' strategic function

The present study indicates that there is one major way in which the experts have a strategic function. When they use their knowledge in process development as stewards (Davis, Schoorman, and Donaldson 1997), the goals of actual assignments are not usually defined in a concrete way and are seldom set quantitatively. Therefore, the traditional understanding that goal setting precedes the choice of means is not applied; rather, it is the method that gives the goals. In that way, the experts help define and operationalize the goals of the operations. The lack of operationalized goals within operations and the under-developed centrally defined goals and strategies create difficult conditions for experts to act strategically, since there is not so much to relate their expertise knowledge to in terms of a clear principal (Eisenhardt 1989) or partner (Teisman and Klijn 2002). Instead, they are free agents in the principal-agent relation, seemingly working with what they themselves find urgent, and are not sufficiently integrated with managers to be viewed as strategic partners. On the other hand, the strategic vacuum provides an opportunity to work with the methods as the expert finds suitable; in this way, the methods lead to goals, which may lead to the development of strategies, since there are fewer obstacles to achieve goal alignment (cf. Van Slyke 2007), or at least that it is easier to avoid goal incongruence. The QEs may provide the prerequisite to a strategy development process that the rational understanding of such processes presume; an operationalized understanding of the goals of the operation. Thus, the QEs have a strategic function, albeit a different one than that which is traditionally identified.

Discussion

Unlike many previous studies, the present study found a vague and under-developed strategic decision-making process to which the experts could link their knowledge. The function of the QEs is primarily determined at the time of establishing the function, and then defined in the interaction with other actors in the organization (Procter and Currie 1999), such as department managers. Our findings coincide with those of Truss (2009), in that the expert function is shaped in its own informal and emergent practices and the experts' positioning is difficult to predict, but it seems difficult to achieve a strategic position. Unlike other studies, this difficulty in becoming strategic cannot be explained by a combination of too little similarity and/or too much difference (e.g. Carlile 2004; Dutton et al. 2001; Hall, Mikes, and Millo 2015). On the contrary, the QEs who have backgrounds as nurses understand the change context and other actors' interpretations, which, according to Caldwell (2003), are prerequisites to achieve a strategic function. Furthermore, the experts in the study demonstrate their methods pedagogically in social interactions with managers (Arena, Arnaboldi, and Azzone 2010), involving a wide range of colleagues early in the process (Dutton et al. 2001), and use their methods as communicative tools (Hall, Mikes, and Millo 2015). Hence, the important criteria (Hall, Mikes, and Millo 2015) that the experts' methods should not be like a black box to the managers and the conclusions should be possible to comprehend, are fulfilled. Accordingly, it does not seem possible to explain the difficulty in becoming strategic because of too little similarity. Nor does it seem plausible that there is too little difference. The methods introduced by the experts were entirely new to the actors in the hospital 10–15 years ago, and have been gradually accepted since. Establishing an in-house consultative expert function seems to be an ideal middle-ground solution between external consultants and traditional staff experts bringing the solutions, regarding appropriate similarities and differences; however, the concept does not provide the desired strategic function to the experts.

There are other explanations for this difficulty. The QEs are organized in a staff unit, linked to the executive management. This position is remote from the department managers' decision-making (Cacciatori and Jacobides 2005), which makes it difficult for these managers to control the experts' initiatives and for the experts to integrate their knowledge in the management control system (Wahlström 2009). What Meidell and Kaarbø (2017) mention as an ideal – that the experts' ideas should be bundled with other strategic matters and linked to the strategic decision-making process – is aggravated by this organizational solution. The experts are not strategically linked to either organizational level. The results of the present study explain the difficulties faced by QEs to attain a position, already as agents to principals. This means that the most traditional of all solutions – namely, a staff linked to the upper management level with the expected function to contribute to the organization's strategy development, at both the executive and department level – seems to have an inherent challenge due to the difficulties at both levels to achieve a function as agents and thereby gradually link to the strategic decision-making process.

Discussion of the results of the present study has, so far, been related to results of previous studies (Peterson 2008; Pritchard 2010), all of which presume there is a strategic decision-making process in the line organization – but this is far from self-evident in a healthcare organization, for example (Currie and Procter 2005). In the studied setting, the question is: Was there really a strategic decision-making process to

which the QEs should contribute? The present study demonstrates that the remaining function of the experts is as stewards. In that function, they contribute, to some extent, to strategy development in an emergent and iterative strategy process through several different organizational actors' interplay (Bryson, Berry, and Yang 2010). Attempts to act as agents on behalf of the executive management and try to force the department and the unit managers to adopt a centrally defined strategy appear to have been unfruitful. Also, the agency linked to the department managers does not appear to provide the necessary space for the expert knowledge, and risks transforming the QEs to being local assistants to the department managers.

Conclusion

The aim of this study was to describe and explain the function of quality experts in the iterative and emergent strategy process involving different actors, with particular focus on their contribution to strategic management in the interplay with line managers. The study shows that although managers and experts share the opinion that the experts should have a strategic function, they do not actually serve this function in reality (cf. Truss 2009). Furthermore, they have difficulty becoming linked as agents to the executive management because the experts' interests lie primarily in improving care for patients rather than in reducing costs. The experts do not seem to be aligned with the strategic issues of the executive management (cf. Meidell and Kaarbø 2017). The department managers wish to link the experts as agents; however, since it is hard to see whether they have any strategic decision-making, the function as agents would be a way to control the experts from doing all kinds of administrative work and participating in solving problems emergent in the care giving. The position in the organizational hierarchy, which is common for experts, seems to block any change in this situation (Cacciatori and Jacobides 2005; Truss 2008; Wahlström 2009). Instead, the experts act as stewards. Previous explanations of difficulties exerting influence on managers' strategic decision-making, due to an unfortunate balance between similarities and differences (Arena, Arnaboldi, and Azzone 2010; Dutton et al. 2001; Freidson 1970/2007; Hall, Mikes, and Millo 2015; Truss 2009), do not seem to be adequate in this studied case. From the QEs' organizational position, the function as steward seems to be most realistic in a setting where there are strong competing logics among the politicians, the executive management and the care-giving professionals.

The main conclusion and contribution of this study is that, in a setting of strong competing logics, which prohibit a common strategy development process in the organization, experts may have a function to contribute in an iterative and emergent strategy process in a role as stewards. In the absence of any dominating logic, it is not possible for experts to obtain a position as partners as long because they are not linked to a meta logic and regarded by the key actors' as a resource to contribute to that logic. To reach a general agreement, such a meta logic must be justified in reference to the common good (Boltanski and Thévenot 1986). Theories upon which NPM rests implicitly assume that a public sector organization may have such an unquestioned logic like a private company guiding the operation. Since this assumption is not fulfilled and NPM does not theorize how a complex organization should develop such a meta logic, the expected role of QEs as partners is not realistic. Instead, the present study demonstrates how the experts can exert their function otherwise. By using a combination of specific methods and concepts and a consultative process method, the means guide the goals, which operationalizes the goals in the plan of the operations at the department level and guides

new initiatives involving the experts. The goals, which can be operationalized, emerge from the processes that the experts are supporting by their methods. In so doing, we provide more knowledge on how experts contribute to the multifaceted and multilevel strategy process in complex organizations such as public organizations. In a broader sense, debate continues about whether there is a transition to post-NPM (Osborne 2010) or if there are fewer signs of NPM de-institutionalization than one might think (Trenholm and Ferlie 2013). A full post-NPM transition would indicate that QEs had functions as partners, which we see few signs of. NPM would rather assume QEs as agents, which is not evident. QEs foremost as stewards can be seen as post-NPM is entering, but it is not a transition, rather an addition to NPM (Andersson and Liff 2012).

The experts' inherent opinions of what to achieve, and their knowledge of what other actors in the organization perceive as important to achieve, guide the experts in their application of the technical methods and processing. While QEs have enacted a realistic function, many of the actors in the organization, including many of the experts themselves, are dissatisfied with the function as stewards. Consequently, the experts are involved in low-priority tasks and their competence is neglected due to decisions. One practical implication of this study would be to pinpoint the relevance of accepting and promoting the experts as stewards. The QEs could advance this function by further professionalization.

The results of this study are transferable to the relationship between line managers and different kinds of experts in other hospitals, similar to the archetypical acute care institution described by Glouberman and Mintzberg (2001), where several kinds of other support functions held by different kinds of semi-professionalized experts have emerged as a consequence of NPM (Ackroyd, Kirkpatrick, and Walker 2007). However, future research could include other theoretical perspectives, considering role ambiguity, identity issues and power aspects among professional actors, to further understand the possibilities of an expert function, like QE, to contribute to the effectuation of the core operations.

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